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TO: **Arkansas Medicaid Health Care Providers - Dental**

DATE: **April 1, 2005**

SUBJECT: **PROPOSED - Provider Manual Update Transmittal No. 70**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
213.000 – 214.000	10-13-03	213.000 – 214.000	4-1-05
216.100	10-13-03	216.100	4-1-05
216.300	10-13-03	216.300	4-1-05
223.000	10-13-03	223.000	4-1-05
226.000	10-13-03	226.000	4-1-05
229.000	10-13-03	229.000	4-1-05
260.000 – 262.100	10-13-03	260.000 – 262.100	4-1-05
262.400 – 263.100	10-13-03	262.400 – 263.100	4-1-05
263.300 – 263.420	10-13-03	263.300 – 263.420	4-1-05
263.422	10-13-03	263.422	4-1-05

Explanation of Updates

Section 213.000 is revised to add information about the tooth numbering system for regular and supernumerary teeth.

Section 214.000 is revised to add information regarding extension of benefits for consultations for individuals under age 21 and to remove obsolete information.

Section 216.100 is revised to remove obsolete information.

Section 216.300 is revised to add information that X-rays are to be labeled with the dentist's and recipient's provider numbers and to remove obsolete information.

Section 223.000 is included to revise the heading of the section and to include information about full dentures.

Section 226.000 is revised to add information regarding procedures involved in submitting dental molds with the orthodontic dental plans. Information has also been included to advise providers of the procedures involved in treatment plans when a patient has moved within the state. Obsolete information has been removed from the section.

Section 229.000 is revised to advise providers that reconstructive surgery for cosmetic purposes or implants are not covered for individuals age 21 and over. Information has also been included to advise that adult dental care services may only be submitted on paper claims.

Sections 260.000 and 262.000 are revised to change the date of service and to remove obsolete information.

Section 261.000 is revised to advise that dental providers must use the American Dental Association (ADA) claim form to bill for services. Obsolete information has been removed from the section.

Section 262.100 is revised to remove several procedure codes. **D4240** and **D4241** have been removed as they are no longer payable procedure codes. Procedure codes **D7640, D7740** and **D7630** have been removed because the codes are payable only to oral surgeons. Local codes have been removed from the list because they are no longer payable. Other changes, enumerated in past official notices and remittance advice forms, are incorporated in the section. Obsolete information has been deleted.

Section 262.400 is revised to add special billing procedures regarding complete and single intraoral film and to remove obsolete information.

Sections 263.000 is revised to advise that oral surgeons billing on the CMS-1500 must use CPT procedure codes.

Section 263.100 is revised to remove obsolete information and to correct typographical errors.

Sections 263.300 through 263.410 are revised to remove obsolete information and correct typographical errors.

Section 263.420 is included to advise providers to use modifier 22 with the appropriate anesthesia procedure code. The local code Z9910 has been deleted and obsolete information has been removed from the section.

Section 263.422 is revised to remove obsolete information.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

213.000 Tooth Numbering 4-1-05

Arkansas Medicaid uses an enumeration system to identify regular and supernumerary teeth in children and adults.

A. The system was devised by the American Dental Association in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

B. It includes a numbering system to identify permanent and permanent supernumerary teeth and an alpha arrangement to identify both regular and deciduous supernumerary teeth.

1. Valid values for regular permanent teeth include the numbers 1 through 32.
2. Numbers 51 through 82 indicate supernumerary permanent teeth.
3. Alpha letters A through T indicate regular deciduous teeth.
4. AS through TS indicate supernumerary deciduous teeth.

View or print a description of the tooth numbering method to be used for all Medicaid claims.

214.000 Consultations 4-1-05

A consultation includes services provided by an oral surgeon whose opinion or advice is requested by an oral surgeon or other appropriate source for the further evaluation and/or management of a specific problem. When the consulting oral surgeon assumes responsibility for the continuing care of the patient, any subsequent service provided by him or her is not a consultative service.

Consultations are limited to two per recipient per year in an oral surgeon's or physician's office. This yearly limit is based on the state's fiscal year, July 1 through June 30. Extensions of this benefit are available to recipients under the age of 21 when the consultation is medically necessary.

These procedures must be billed on the American Dental Association (ADA) claim form by oral surgeons enrolled in the Medicaid Program when the procedure is provided to an eligible Medicaid recipient and is medically necessary.

216.100 Complete Series Radiographs 4-1-05

A complete series of intraoral radiographs is allowable within a single state fiscal year (SFY) of July 1 through June 30 only once every five years, except under unusual circumstances (e.g., traumatic accident).

A. A complete series must include 10 to 18 intraoral films, including bitewings or a panoramic film including bitewings. Two bitewings are covered when a panoramic X-ray is taken on the same date.

B. Only one complete series is covered. A complete series may be:

1. Intraoral, including bitewings, or
2. Panoramic, including bitewings.

C. When an emergency extraction is done on the day a complete series is taken, no additional X-rays will be covered.

D. Prior authorization (PA) is required for panoramic radiographs of children under age six.

E. When referrals are made, the patient's X-rays must be sent to the specialist.

F. For instructions when billing for a complete series, see section 262.400.

216.300 Intraoral Film 4-1-05

When submitting a claim for an intraoral single film, indicate the middle tooth number. Procedure code D0220 must be used for the first film and procedure code D0230 for each additional single film. Medicaid will only cover the complete series or the submitted group of individual X-rays. X-rays are to be mounted, marked R and L, labeled with the dentist's provider number and the recipient identification number and stapled to the back of the claim form, as noted in section 216.000.

223.000 Removable Prosthetic Services (Full and Partial Dentures, Including Repairs) 4-1-05

Full and acrylic partial dentures are allowable for patients under age 21. Full dentures or acrylic partial dentures may be approved for use by individuals under age 21 instead of fixed bridges. A complete series of X-rays and a complete treatment plan, including tooth numbers to be replaced by full or partial dentures, must be submitted with requests for full or acrylic partial dentures. All dentures, either full or acrylic partials, require prior authorization.

Repairs of dentures are allowable with a history and date of original insertion and prior authorization for eligible recipients under age 21. See section 262.100 for applicable procedure codes.

226.000 Orthodontics 4-1-05

Orthodontic treatment is available for eligible recipients under age 21 with prior authorization. Orthodontic treatment is approved on a very selective basis when a handicapping malocclusion is affecting the patient's physical and/or psychological health. The dental provider is responsible for evaluating the attitude of the patient and the parent/guardian toward the treatment and their ability and/or willingness to follow instructions and meet appointments promptly. This evaluation should precede taking orthodontic records. **Please note: ARKids First-B does not cover orthodontic treatment.**

All orthodontic treatment is classified as either minor treatment for tooth guidance or as comprehensive treatment. Minor treatment for tooth guidance will be allowed with prior authorization when necessary to correct functional problems.

All orthodontic treatment, including functional appliances, must be requested on the ADA claim form. The ADA claim form must be accompanied by the Request for Orthodontic Treatment form (form DMS-32-0). **View or print form DMS-32-0**.

The maximum age of eligibility for full-banded 24-month orthodontic treatment is through age 20. Functional-banded orthopedic appliances require the same diagnostic records as full-banded orthodontics. The minimum total score on a Request for Orthodontic Treatment for consideration of comprehensive orthodontic treatment is 26. This value will be rescored by a Medicaid dental consultant based on the casts and radiographs provided with the request.

Diagnostic casts (dental molds), cephalometric film, photos, a complete series of X-rays and any information not evident on diagnostic materials must be submitted for review with the ADA claim form. Dental molds must be submitted along with the treatment plan. The dental molds must not be submitted separately and the provider's and the recipient's full names must be clearly inscribed on the upper and lower casts.

If oral surgery is necessary in addition to orthodontic treatment, the oral surgeon must submit his or her treatment plan with the orthodontic treatment plan.

When orthodontic treatment is approved, a procedure code for appliance insertion will be issued. This procedure code includes payment for the appliance, the diagnostic records, casts (dental molds and X-rays) and the post-treatment retainer. This code and the prior authorization control number will be sent to the provider on the ADA form. The date the treatment is to be completed will also be indicated. No reimbursement for treatment beyond that date will be made. The Authorization for Payment for Services Provided form (form MAP-8) and a copy of the treatment plan must be kept by the provider in the patient's file. **View or print MAP-8 form and instructions.**

When treatment is denied or for any reason is not performed, the provider is allowed to submit a claim for the orthodontic records. This includes orthodontic consultation, cephalometric film, diagnostic casts (dental molds), photos and a complete series or panoramic X-ray if taken by the dentist. This claim must be approved by the Medicaid dental consultant.

All claims for orthodontic treatment are to be submitted on the ADA claim form according to directions detailed in section 262.300 of this manual. Claims must be submitted within 12 months from the date of service.

When a patient is uncooperative for any reason, except for the situation noted in the following paragraph, termination of the treatment will be left to the discretion of the provider. A report should be sent to the Division of Medical Services, Dental Care Unit, with a pro-rated refund to Arkansas Medicaid for the balance of the uncompleted treatment plan. **View or print DMS Dental Care Unit contact information.**

When an orthodontic patient moves within the state after initial treatment has begun, the original provider should reimburse the second provider directly for the pro-rated fees remaining. When the second provider submits his or her treatment plan to continue the orthodontic patient's

treatment, the provider must submit the orthodontic records of treatment performed by the original provider.

229.000 Adult Services 4-1-05

In general, Arkansas Medicaid does not cover dental treatment for adults who are 21 years of age and older. An exception to this general rule is dental treatment that is medically necessary.

Medically necessary dental treatment is defined as dental care that will stabilize a life-threatening medical condition, or dental care that, if not done, could result in death.

All medically necessary dental care must be pre-approved by medical and dental consultants at the Division of Medical Services. All adult dental care services may only be submitted on paper claims.

The review process must include:

A. The identification of a life-threatening medical problem affected by oral health**.** Some examples of such conditions are:

1. HIV/AIDS patients with infections the immune system is unable to fight
2. Transplant patients with infected teeth or gums
3. Cancer radiation treatments to the head/neck/jaw

B. The PCP Referral Form (DMS-2610) must be completed by the primary care physician detailing the medical condition and the effects the oral health problems have on the overall health of the recipient. **View or print form DMS-2610**.

C. Upon completion, the PCP Referral Form (DMS-2610) must be submitted to the Division of Medical Services by the dental professional who will be providing the services. Any supporting information, including X-rays, to further substantiate medically necessary treatment must be submitted.

D. Upon receipt, Medicaid medical and dental consultants will evaluate the information submitted and authorize the dental treatment, if any, that Medicaid will reimburse. After the review process is completed, the panel will return any X-rays along with recommendations to the requesting dental professional.

E. The office of the dental professional will notify the recipient regarding the decision of the Medicaid consultants, and if appropriate, arrange to begin dental care.

The medical/dental consultants will only approve dental treatment for adults who strictly meet the medical necessity criteria.

Under no circumstance will the Dental Program purchase dentures or any other similar prosthetic device for individuals age 21 and over. Oral surgery, such as reconstructive surgery for cosmetic purposes, is not a covered service, nor are implants a covered service.

260.000 BILLING PROCEDURES 4-1-05

261.000 Introduction to Billing 4-1-05

Dental providers must use the American Dental Association (ADA) form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid recipients. Each claim may contain charges for only one recipient.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

262.000 ADA Billing Procedures 4-1-05

262.100 ADA Procedure Codes 4-1-05

The following ADA procedure codes are covered by the Arkansas Medicaid Program. These codes are payable for individuals under the age of 21. The codes are non-payable for individuals age 21 and over unless a life-threatening medical necessity exists.

Beside each code is a reference chart that indicates if X-rays are required, if prior authorization (PA) is required and the age group(s) for which the procedure is covered.

ADA Code	Description	Coverage Under 21	Coverage 21 and Over	Submit X-Ray with Treatment Plan
Child Health Services (EPSDT) Dental Screening (See section 215.000)				
D0120	CHS/EPSDT initial dental Exam	Yes	No	No
D0140	CHS/EPSDT interperiodic dental Exam	Yes W-PA	No	No
Radiographs (See sections 216.000 – 216.300)				
D0210	Intraoral – complete series (including bitewings)	Yes	No	No
D0220	Intraoral – periapical - first film	Yes	No	No
D0230	Intraoral – periapical - each additional film	Yes	No	No
D0240	Intraoral – occusal film	Yes	No	No
D0250	Extraoral - first film	Yes	No	No
D0260	Extraoral - each additional film	Yes	No	No
D0272	Bitewings - two films	Yes	No	No
D0330	Panoramic film	Yes	No	No
D0340	Cephalometric film	Yes W-PA	No	No
Tests and Laboratory				
D0470	Diagnostic casts	Yes W-PA	No	No
D0350	Diagnostic photographs	Yes W-PA	No	No
Preventive				
Dental Prophylaxis (See section 217.100)				
D1120	Prophylaxis – child (ages 0-9)	Yes	No	No

ADA Code	Description	Coverage Under 21	Coverage 21 and Over	Submit X-Ray with Treatment Plan
D1110	Prophylaxis – adult (ages 10-20)	Yes	No	No
Topical Fluoride Treatment (Office Procedure) (See Section 217.100)				
D1201	Topical application of fluoride (including prophylaxis) - child (ages 0-9)	Yes	No	No
D1205	Topical application of fluoride (including prophylaxis) - adult (ages 10-20)	Yes	No	No
Dental Sealants (See section 217.200)				
D1351	Sealant per tooth (1st and 2nd permanent molars only)	Yes	No	No
Space Maintainers (See section 218.000)				
D1510	Space maintainer - fixed – unilateral	Yes W-PA	No	Yes
D1515	Space maintainer - fixed – bilateral	Yes W-PA	No	Yes
D1525	Space maintainer - removable-bilateral	Yes W-PA	No	Yes
Restorations (See sections 219.000 – 219.200)				
Amalgam Restorations (including polishing) (See section 219.100)				
D2140	Amalgam – one surface	Yes	No	No
D2150	Amalgam – two surfaces	Yes	No	No
D2160	Amalgam - three surfaces	Yes	No	No
D2161	Amalgam - four or more surfaces	Yes	No	No
Composite Resin Restorations (See section 219.200)				
D2330	Resin - one surface, anterior, permanent	Yes	No	No
D2331	Resin - two surfaces, anterior, permanent	Yes	No	No
D2332	Resin - three surfaces, anterior, permanent	Yes	No	No
D2335	Resin - four or more surfaces or involving incisal angle, permanent	Yes W-PA	No	Yes
Crowns-Single Restoration Only (See section 220.000)				
D2710	Crown - resin (laboratory)	Yes W-PA	No	Yes
D2752	Crown - porcelain-ceramic substrate	Yes W-PA	No	Yes
D2920	Re-cement crown	Yes	No	Yes
D2930	Prefabricated stainless steel crown - primary	Yes	No	No
D2931	Prefabricated stainless steel crown - permanent	Yes W-PA	No	Yes

ADA Code	Description	Coverage Under 21	Coverage 21 and Over	Submit X-Ray with Treatment Plan
Endodontia (See section 221.000)				
Pulpotomy				
D3220	Therapeutic pulpotomy (excluding final restoration)	Yes	No	No
D3221	Gross pulpal debridement, primary and permanent teeth	Yes W-PA	No	No
Root canal therapy (including treatment plan, clinical procedures and follow-up care)				
D3310	One canal (excluding final restoration)	Yes W-PA	No	Yes
D3320	Two canals (excluding final restoration)	Yes W-PA	No	Yes
D3330	Three canals (excluding final restoration)	Yes W-PA	No	Yes
Periapical Services				
D3410	Apicoectomy (per tooth) - first root	Yes W-PA	No	Yes
Periodontal Procedures (See section 222.000)				
Surgical Services (including usual postoperative services)				
D4341	Periodontal scaling and root planing	Yes W-PA	No	Yes
D4910	Periodontal maintenance procedures (following active therapy)	Yes W-PA	No	Yes
Complete dentures (Removable Prosthetics Services) (See section 223.000)				
D5110	Complete denture – maxillary	Yes W-PA	No	Yes
D5120	Complete denture – mandibular	Yes W-PA	No	Yes
Partial Dentures (Removable Prosthetic Services) (See section 223.000)				
D5211	Upper partial - acrylic base (including any conventional clasps and rests)	Yes W-PA	No	Yes
D5212	Lower partial - acrylic base (including any conventional clasps and rests)	Yes W-PA	No	Yes
Repairs to Partial Denture (See section 223.000)				
D5610	Repair acrylic saddle or base	Yes W-PA	No	No
D5620	Repair cast framework	Yes W-PA	No	No
D5640	Replace broken teeth - per tooth	Yes W-PA	No	No
D5650	Add tooth to existing partial denture	Yes W-PA	No	No
Fixed Prosthodontic Services (See section 224.000)				
D6930	Re-cement bridge	Yes W-PA	No	No
Oral Surgery (See section 225.000)				
Simple Extractions – (includes local anesthesia and routine postoperative care) (See section 225.100)				
D7140	Single tooth	Yes	No	No

ADA Code	Description	Coverage Under 21	Coverage 21 and Over	Submit X-Ray with Treatment Plan
D7111	Each additional tooth	Yes	No	No
Surgical Extractions – (includes local anesthesia and routine postoperative care) (See section 225.200)				
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	Yes W-PA	No	Yes
D7220	Removal of impacted tooth -soft tissue	Yes W-PA	No	Yes
D7230	Removal of impacted tooth -partially bony	Yes W-PA	No	Yes
D7240	Removal of impacted tooth -completely bony	Yes W-PA	No	Yes
D7241	Removal of impacted tooth -completely bony, with unusual surgical complications	Yes W-PA	No	Yes
D7250	Surgical removal of residual tooth roots (cutting procedure)	Yes W-PA	No	Yes
Other Surgical Procedures				
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	Yes W-PA	No	Yes
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)	Yes W-PA	No	Yes
D7285	Biopsy of oral tissue - hard	Yes W-PA	No	Yes
D7286	Biopsy of oral tissue - soft	Yes W-PA	No	Yes
Osteoplasty for Prognathism, Micrognathism or Apertognathism				
D7510	Incision and drainage of abscess, intraoral soft tissue	Yes W-PA	No	No
Other Repair Procedures				
Bill on paper	LeFort I (maxilla-segmented)	Yes By-RPT	No	Yes
Frenulectomy				
D7960	Frenulectomy (Frenectomy or Frenotomy) Separate procedure	Yes W-PA	No	Yes
Orthodontics (See section 226.000)				
Minor Treatment of Control Harmful Habits				
D8210	Removable appliance therapy	Yes W-PA	No	Yes
D8220	Fixed appliance therapy	Yes W-PA	No	Yes
Comprehensive Orthodontic Treatment – Permanent Dentition				
D8070	Class I Malocclusion	Yes W-PA	No	Yes

ADA Code	Description	Coverage Under 21	Coverage 21 and Over	Submit X-Ray with Treatment Plan
D8080	Class II Malocclusion	Yes W-PA	No	Yes
D8090	Class III Malocclusion	Yes W-PA	No	Yes
Other Orthodontic Devices				
D8999	Unspecified orthodontic procedure, by report	Yes W-PA	No	Yes
D9110	Palliative treatment with dental pain	Yes W-PA	No	No
D9220	General Anesthesia - first 30 minutes	Yes W-PA	No	Yes
D9221	General Anesthesia – each 15 minutes	Yes W-PA	No	No
D9230	Analgesia N20	Yes *By RPT for request for more than 1 unit per day	No	No
D9630	Conscious Sedation	Yes W-PA By RPT	No	No
Professional Visits (See section 227.000)				
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	Yes W-PA	No	No
D9440	Office visit - after regularly scheduled hours	Yes W-PA	No	No
Inpatient Hospital Services (See section 228.100)				
D9220	Inpatient hospitalization – for hospital only	Yes W-PA	No	No
Outpatient Hospital Services (See section 228.200)				
0361*	Outpatient hospitalization - for hospital only	Yes W-PA	No	No
0360*	Outpatient hospitalization - for hospital only	Yes W-PA	No	No
0369*	Outpatient hospitalization - for hospital only	Yes W-PA	No	No
0509*	Outpatient hospitalization - for hospital only	Yes W-PA	No	No

* Revenue code

Procedure codes D9220 and D9221 are payable for individuals over age 21 when provided as medically necessary dental treatment. See section 229.000 for a description of medically necessary dental treatment for adults.

262.400 Special Billing Procedures for ADA Claim Form 4-1-05

A. Each procedure must be shown on a separate line, such as:

1. Extractions
2. Upper partials
3. Lower partials
4. Upper denture relines
5. Lower denture relines

B. When a complete intraoral series is made, the dentist must use procedure code D0210 rather than indicating each intraoral film on a separate line.

C. When submitting a claim for an intraoral single film, indicate the middle tooth number. Procedure code D0220 must be used for the first film and procedure code D0230 for each additional single film. Medicaid will only cover the complete series or the submitted group of individual X-rays. X-rays are to be mounted, marked R and L, labeled with the dentist's provider number and the recipient identification number and stapled to the back of the claim form.

D. Post-operative X-rays must accompany all claims with root canals. The claim and X-rays should be sent to the Arkansas Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information**.

E. Prophylaxis and fluoride must be indicated on the same line of the form using code D1201 for patients age 9 and under and D1205 for patients ages 10 through 20. If prophylaxis and fluoride are submitted as separate procedures, they will be combined on the claim before processing them for payment.

F. Indicate the tooth number when submitting claims for code D0220 and D0230, intraoral single film. When a complete series is made, providers must use code D0210 rather than indicating each tooth on a separate line.

G. Upper and lower full dentures must be billed on a separate line, using the appropriate code for upper or lower dentures.

H. The ADA claim form on which the treatment plan was submitted to obtain prior authorization may be used to submit the claim for payment. If this is done, only the Request for Payment portion of the form is to be completed. If not, a new form may be used with the prior authorization control number indicated in Field 9 of the claim form. If a new form is used, the patient and provider data and the request for payment sections must be completed.

I. Combine all four quadrants times 2, 3 or 4 when using procedure codes 04210 (gingivectomy or gingivoplasty-per quadrant) and D4220 (gingival curettage, by report).

J. Use procedure code D1110 for prophylaxis-adolescent, ages 10 through 20, and procedure code D1120 for prophylaxis-child, ages 0 through 9.

263.000 CMS-1500 Billing Procedures 4-1-05

Oral surgeons billing CPT procedure codes must use the CMS-1500 form.

263.100 CPT Procedure Codes 4-1-05

Procedure Codes

10060	10061	10120	10121	10140	10160	10180	11000
11001	11040	11041	11042	11043	11044	11050	11051
11052	11101	11200	11201	11305	11306	11307	11308
11310	11311	11312	11313	11420	11440	11620	11621
11622	11623	11624	11626	11640	11641	11642	11643
11644	11646	12001	12002	12004	12005	12006	12007
12011	12013	12014	12015	12016	12017	12018	12020
12021	12031	12032	12034	12035	12036	12037	12041
12042	12044	12045	12046	12047	12051	12052	12053
12054	12055	12056	12057	13120	13121	13131	13132
13150	13151	13152	13160	13300	14020	14021	14040
14041	14060	14061	14300	15000	15100	15101	15120
15121	15220	15221	15240	15241	15260	15261	15350
15400	15570	15572	15574	15576	15580	15600	15610
15620	15630	15732	15740	15750	15755	15760	15770
15840	15841	15842	15845	15850	15851	15852	15860
16000	16010	16015	16020	16025	16030	16035	16040
16041	16042	17000	17001	17002	17010	17107	17108
17110	17200	17201	17250	17270	17271	17272	17273
17274	17276	17280	17281	17282	17283	17284	17286
17304	17305	17306	17307	17310	17340	17999	20000
20005	20525	20605	20615	20670	20680	20690	20692
20693	20694	20900	20902	20910	20912	20920	20922
20924	20926	20960	20962	20969	20970	20971	20999
21010	21015	21025	21026	21029	21030	21031	21032
21034	21040	21041	21044	21045	21050	21060	21070
21100	21110	21116	21206	21210	21215	21230	21235
21240	21242	21243	21260	21261	21263	21267	21268
21270	21275	21280	21282	21295	21296	21299	21300
21315	21320	21325	21330	21335	21336	21337	21338
21339	21340	21343	21344	21345	21346	21347	21348
21355	21356	21360	21365	21366	21385	21386	21387
21390	21395	21400	21401	21406	21407	21408	21421
21422	21423	21431	21432	21433	21435	21436	21440
21445	21450	21451	21452	21453	21454	21461	21462
21465	21470	21480	21485	21490	21493	21494	21495
21499	21501	21550	21555	21557	29800	29804	29909

30000	30020	30100	30117	30118	30120	30124	30125
30130	30140	30150	30160	30200	30210	30220	30300
30310	30320	30520	30540	30545	30560	30580	30600
30620	30630	30801	30802	30901	30903	30905	30906
30915	30920	30930	30999	31000	31002	31020	31030
30132	30140	31050	31051	31070	31075	31080	31081
31084	31085	31086	31087	31090	31225	31230	31231
31233	31235	31237	31238	31239	31240	31276	31287
31288	31290	31291	31292	31293	31294	31299	31500
31502	31513	31515	31530	31531	31535	31536	31600
31601	31603	31605	31820	31825	31830	36000	36400
36405	36406	36410	36600	36620	36625	38300	38505
38525	38542	38700	38720	38724	38740	38745	40490
40500	40510	40520	40525	40527	40530	40650	40652
40654	40700	40701	40702	40720	40761	40799	40800
40801	40806	40808	40810	40812	40814	40816	40818
40820	40830	40831	40840	40842	40843	40844	40845
40899	41000	41005	41006	41007	41008	41009	41010
41015	41016	41017	41018	41108	41110	41112	41113
41114	41116	41120	41130	41135	41140	41145	41150
41153	41155	41250	41251	41252	41500	41510	41520
41599	41800	41805	41806	41820	41821	41822	41823
41825	41826	41827	41828	41830	41850	41870	41872
41874	41899	42000	42100	42104	42106	42107	42120
42140	42145	42160	42180	42182	42200	42205	42210
42215	42220	42225	42226	42227	42235	42260	42280
42281	42299	42300	42305	42310	42320	42325	42326
42330	42335	42340	42400	42405	42408	42409	42410
42415	42420	42425	42426	42440	42450	42500	42505
42507	42508	42509	42510	42550	42600	42650	42660
42665	42699	42720	42725	42800	42802	42804	42806
42808	42810	42815	42880	42900	42950	42953	42960
42961	42962	42970	42971	42972	42999	43204	43205
43219	43227	43228	64400	64402	64405	64550	64716
64722	64727	64732	64734	64736	64738	64740	64742
64744	64788	64790	64792	64795	64830	64864	64872
64874	64885	64886	64901	64902	64905	64907	64999

67599	67715	67810	67820	67825	67830	67835	67875
67880	67882	67902	67903	67904	67906	67908	67909
67911	67930	67935	67950	67961	67966	67971	67973
67974	67975	67999	68400	68420	68440	68530	68720
68745	68750	68760	68761	68770	68800	68825	68840
68850	68899	69100	69110	69200	69205	69210	69399
70030	70100	70110	70140	70150	70160	70170	70210
70220	70250	70260	70300	70310	70320	70328	70330
70332	70336	70350	70355	70360	70380	70390	76000
76100	76140	76499	90780	90799	92511	95831	95851
95868	95937	95999	97010	97014	97124	97703	99201
99202	99203	99204	99205	99211	99212	99213	99214
99215	99217	99218	99219	99220	99221	99222	99223
99231	99232	99233	99238	99241	99242	99243	99244
99245	99251	99252	99253	99254	99255	99271	99272
99273	99274	99275	99281	99282	99283	99284	99285
99288	99301	99302	99303	99311	99312	99313	99341
99342	99343	99351	99352	99353	99354	99355	99356
99357							

A. The procedures listed above must be billed with the appropriate type of service code (1, Medical), (2, Surgical) or (C, P or T - Lab, X-Ray, or Machine Test).

B. Enter the type of service code in Field 24C of the CMS-1500 claim form.

C. If these procedures are the result of a Child Health Services (EPSDT) screen/referral, enter “E” in Field 24H.

D. These procedures are restricted to the following places of service: inpatient hospital, outpatient hospital, doctor’s office, patient’s home, nursing home and skilled nursing facility.

E. Radiology procedures are payable only in the dentist’s office. The place of service (POS) codes may be found in section 262.200 of this manual. **These services require a PCP referral.**

The claim form CMS-1500 must be used by dentists billing the Medicaid Program for these medical procedures. Each recipient’s services must be billed on a separate form. See section 263.300 for complete billing instructions.

When billing for extractions (procedure code 41899), a listing of teeth extracted by date, tooth number and ADA code number must be attached.

Recipients in the Child Health Services (EPSDT) Program are not benefit limited.

The provider should carefully read and adhere to the following instructions so that claims may be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible. Handwritten claims must be completed neatly and accurately.

263.300 Billing Instructions - CMS-1500 - Paper Claims Only 4-1-05

The CMS-1500 claim form must be completed when billing for procedure codes listed in sections 263.100 through 263.110. The following numbered items correspond to numbered fields on the claim form. **View a CMS-1500 sample form**.

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

COMPLETION OF FORM

Field Name and Number		Instructions for Completion
1.	Type of Coverage	This field is not required for Medicaid.
1a.	Insured's I.D. Number	Enter the patient's 10-digit Medicaid identification number.
2.	Patient's Name	Enter the patient's last name and first name.
3.	Patient's Birth Date	Enter the patient's date of birth in MM/DD/YY format as it appears on the Medicaid identification card.
	Sex	Check "M" for male or "F" for female.
4.	Insured's Name	Required if there is insurance affecting this claim. Enter the insured's last name, first name and middle initial.
5.	Patient's Address	Optional entry. Enter the patient's full mailing address, including street number and name (post office box or RFD), city name, state name and ZIP code.
6.	Patient Relationship to Insured	Check the appropriate box indicating the patient's relationship to the insured if there is insurance affecting this claim.
7.	Insured's Address	Required if insured's address is different from the patient's address.
8.	Patient Status	This field is not required for Medicaid.
9.	Other Insured's Name	If patient has other insurance coverage as indicated in Field 11D, enter the other insured's last name, first name and middle initial.
	a. Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
	b. Other Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.
	c. Employer's Name or School Name	Enter the employer's name or school name.
	d. Insurance Plan Name or Program Name	Enter the name of the insurance company.
10.	Is Patient's Condition Related to:	

	a. Employment	Check “YES” if the patient’s condition was employment related (current or previous). If the condition was not employment related, check “NO.”
	b. Auto Accident	Check the appropriate box if the patient’s condition was auto accident related. If “YES,” enter the place (two-letter state postal abbreviation) where the accident took place. Check “NO” if not auto accident related.
	c. Other Accident	Check “YES” if the patient’s condition was other accident related. Check “NO” if not other accident related.
10d.	Reserved for Local Use	This field is not required for Medicaid.
11.	Insured’s Policy Group or FECA Number	Enter the insured’s policy group or FECA number.
	a. Insured’s Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.
	b. Employer’s Name or School Name	Enter the insured’s employer’s name or school name.
	c. Insurance Plan Name or Program Name	Enter the name of the insurance company.
	d. Is There Another Health Benefit Plan?	Check the appropriate box indicating whether there is another health benefit plan.
12.	Patient’s or Authorized Person’s Signature	This field is not required for Medicaid.
13.	Insured’s or Authorized Person’s Signature	This field is not required for Medicaid.
14.	Date of Current: Illness Injury Pregnancy	Required only if medical care being billed is related to an accident. Enter the date of the accident.
15.	If Patient Has Had Same or Similar Illness, Give First Date	This field is not required for Medicaid.
16.	Dates Patient Unable to Work in Current Occupation	This field is not required for Medicaid.
17.	Name of Referring Physician or Other Source	Primary care physician (PCP) referral is not required for dental services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a.	I.D. Number of Referring Physician	Enter the 9-digit Medicaid provider number of the referring physician.
18.	Hospitalization Dates Related to Current Services	For services related to hospitalization, enter hospital admission and discharge dates in MM/DD/YY format.
19.	Reserved for Local Use	Not applicable to dental.
20.	Outside Lab?	This field is not required for Medicaid.

21. Diagnosis or Nature of Illness or Injury	Enter the diagnosis code from the ICD-9-CM. Up to four diagnoses may be listed. Arkansas Medicaid requires providers to comply with CMS diagnosis coding requirements found in the ICD-9-CM edition current for the claim receipt dates.
22. Medicaid Resubmission Code	Reserved for future use.
Original Ref No.	Reserved for future use.
23. Prior Authorization Number	Enter the prior authorization number, if applicable.
24. A. Dates of Service	Enter the "from" and "to" dates of service, in MM/DD/YY format, for each billed service. 1. On a single claim detail (one charge on one line), bill only for services within a single calendar month. 2. Providers may bill, on the same claim detail, for two (2) or more *sequential* dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the span.
B. Place of Service	Enter the appropriate place of service code. See section 263.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See section 263.200 for codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from sections 263.100 through 263.110.
Modifier	Use applicable modifier.
E. Diagnosis Code	Enter a diagnosis code that corresponds to the diagnosis in Field 21. If preferred, simply enter the corresponding line number ("1," "2," "3," "4") from Field 21 on the appropriate line in Field 24E instead of reentering the actual corresponding diagnosis code. Enter only <u>one</u> diagnosis code or one diagnosis code line number on each line of the claim. If two or more diagnosis codes apply to a service, use the code most appropriate to that service. The diagnosis codes are found in the ICD-9-CM.
F. $ Charges	Enter the charge for the service. This charge should be the provider's usual charge to private clients. If more than one unit of service is being billed, enter the charge for the total number of units billed.
G. Days or Units	Enter the units (in whole numbers) of service rendered within the time frame indicated in Field 24A.
H. EPSDT/Family Plan	Enter "E" if services rendered were a result of a Child Health Services (EPSDT) screening/referral.
I. EMG	Emergency - This field is not required for Medicaid.
J. COB	Coordination of Benefit - This field is not required for Medicaid.

	K. Reserved for Local Use	When billing for a clinic or group practice, enter the 9-digit Medicaid provider number of the performing provider in this field and enter the group provider number in Field 33 after "GRP#." When billing for an individual practitioner whose income is reported by 1099 under a Social Security number, DO NOT enter the provider number here. Enter the number in Field 33 after "GRP#."
25.	Federal Tax I.D. Number	This field is not required for Medicaid. This information is carried in the provider's Medicaid file. If it changes, contact Provider Enrollment.
26.	Patient's Account No.	This is an optional entry that may be used for accounting purposes. Enter the patient's account number, if applicable. Up to 16 numeric or alphabetic characters will be accepted.
27.	Accept Assignment	This field is not required for Medicaid. Assignment is automatically accepted by the provider when billing Medicaid.
28.	Total Charge	Enter the total of Field 24F. This field should contain a sum of charges for all services indicated on the claim form. (See NOTE below Field 30.)
29.	Amount Paid	Enter the total amount of funds received from other sources. The source of payment should be indicated in Field 11 and/or Field 9. Do not enter any amount previously paid by Medicaid. Do not enter any payment by the recipient unless the recipient has an insurer that requires co-pay. In such a case, enter the sum of the insurer's payment and the recipient's co-pay amount, without regard to whether the recipient has remitted the co-pay. (See NOTE below Field 30.)
30.	Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge. **NOTE: For Fields 28, 29 and 30, up to 28 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.**
31.	Signature of Physician or Supplier, Including Degrees or Credentials	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32.	Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	If other than home or office, enter the name and address, specifying the street, city, state and ZIP code of the location where services were performed.

33. Physician's/Supplier's Billing Name, Address, ZIP Code & Phone #	Enter the billing provider's name and complete address. Telephone number is requested but not required.
PIN #	This field is not required for Medicaid.
GRP #	Clinic or Group Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#" and the individual practitioner's number in Field 24K. Individual Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#."

263.400 Special Billing Procedure for the CMS-1500 Claim Form 4-1-05

CPT-4 procedure codes must be billed on the CMS-1500 claim form by dentists enrolled in the Medicaid Program when the procedure is provided to an eligible Medicaid recipient and is medically necessary. **View a CMS-1500 sample form.** These procedure codes and their descriptions are located in the *American Medical Association Current Procedural Terminology (CPT)*. Refer to Section III for information on how to purchase a copy of this publication.

NOTE: The Arkansas Medicaid Program will make procedure code 99238 (Hospital Discharge Day Management) payable for type of service code "1" (Medical). Procedure code 99238 may not be billed by providers in conjunction with an initial or subsequent hospital care code (procedure codes 99221 through 99233). Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

NOTE: Covered CPT-4 procedure codes listed in this section are covered by Medicaid for eligible recipients of all ages. The Arkansas Medicaid ADA Procedure Codes are covered only for eligible recipients under the age of 21 years participating in the Child Health Services (EPSDT) Program.

263.410 Multiple Quadrants Billing Instructions 4-1-05

When billing for multiple applications of any of the following procedures on the same date of service in varying quadrants of a recipient's mouth, indicate the number of quadrants (1, 2, 3, 4) in Field 24G:

D1110	D1120	41872	41874

263.420 Anesthesia Services 4-1-05

Anesthesia services are billed using the CMS-1500 claim format.

A. The Arkansas Medicaid Program covers the anesthesia procedure codes (code range 00100 through 01999) listed in the *Current Procedural Terminology (CPT-4*) code book.

B. Providers must use a type of service (TOS) code "7" with the anesthesia procedure codes and must bill anesthesia time.

C. Providers must use anesthesia modifiers P1 through P5 as listed in the CPT manual.

D. Providers may bill electronically unless paper attachments are required.

E. When providers bill on paper, a TOS code is required along with any applicable modifier(s).

The procedure code and the time involved must be entered in Field 24D. The number of units (each 15 minutes, or portion thereof, of anesthesia equals 1 time unit) must be entered in Field 24G. A "7" must be entered in Field 24C. (A cutaway section of a completed claim is located in section 263.422.)

The procedure code listed under the "Qualifying Circumstances" in the Anesthesia Guidelines in the CPT requires a TOS code "1." When surgical field avoidance is a qualifying factor of the anesthesia service, the provider must bill, in addition to the basic anesthesia procedure code, modifier 22, TOS code "1" and must bill "1" unit of service.

Procedure code 00170 may be billed using TOS code "7" for any inpatient or outpatient dental surgery using place of service code "B," "1," "2" or "3," as appropriate. This code does not require prior approval for anesthesia claims.

263.422 Example of Proper Completion of Claim 4-1-05

The following is a cutaway section of the CMS-1500 claim form demonstrating the proper method of entering the following information:

Line No. 1 - Anesthesia for Procedure

Line No. 2 - Qualifying Circumstance

DATE(S) OF SERVICE From MM DD YY	To MM DD YY	Place of Service	Type of Service	PROCEDURES, SERVICES OR SUPPLIES (Explains Unusual Circumstances) CPT HCPCS	Modifier	DIAGNOSIS CODE	S CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
07 15 95		1	7	00170	P3	525.9	xxx xx	4				105967001
				60 minutes	= 4 units							
07 15 95		1	1	99100		525.9	xxx xx	1				105967001

213.000 Tooth Numbering 4-1-05

Arkansas Medicaid uses an enumeration system to identify regular and supernumerary teeth in children and adults.

A. The system was devised by the American Dental Association in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

B. It includes a numbering system to identify permanent and permanent supernumerary teeth and an alpha arrangement to identify both regular and deciduous supernumerary teeth.

1. Valid values for regular permanent teeth include the numbers 1 through 32.
2. Numbers 51 through 82 indicate supernumerary permanent teeth.
3. Alpha letters A through T indicate regular deciduous teeth.
4. AS through TS indicate supernumerary deciduous teeth.

View or print a description of the tooth numbering method to be used for all Medicaid claims.

214.000 Consultations 4-1-05

A consultation includes services provided by an oral surgeon whose opinion or advice is requested by an oral surgeon or other appropriate source for the further evaluation and/or management of a specific problem. When the consulting oral surgeon assumes responsibility for the continuing care of the patient, any subsequent service provided by him or her is not a consultative service.

Consultations are limited to two per recipient per year in an oral surgeon's or physician's office. This yearly limit is based on the state's fiscal year, July 1 through June 30. Extensions of this benefit are available to recipients under the age of 21 when the consultation is medically necessary.

These procedures must be billed on the American Dental Association (ADA) claim form by oral surgeons enrolled in the Medicaid Program when the procedure is provided to an eligible Medicaid recipient and is medically necessary.

216.100 Complete Series Radiographs 4-1-05

A complete series of intraoral radiographs is allowable within a single state fiscal year (SFY) of July 1 through June 30 only once every five years, except under unusual circumstances (e.g., traumatic accident).

A. A complete series must include 10 to 18 intraoral films, including bitewings or a panoramic film including bitewings. Two bitewings are covered when a panoramic X-ray is taken on the same date.

B. Only one complete series is covered. A complete series may be:

1. Intraoral, including bitewings, or
2. Panoramic, including bitewings.

C. When an emergency extraction is done on the day a complete series is taken, no additional X-rays will be covered.

D. Prior authorization (PA) is required for panoramic radiographs of children under age six.

E. When referrals are made, the patient's X-rays must be sent to the specialist.

F. For instructions when billing for a complete series, see section 262.400.

216.300 Intraoral Film 4-1-05

When submitting a claim for an intraoral single film, indicate the middle tooth number. Procedure code D0220 must be used for the first film and procedure code D0230 for each additional single film. Medicaid will only cover the complete series or the submitted group of individual X-rays. X-rays are to be mounted, marked R and L, labeled with the dentist's provider number and the recipient identification number and stapled to the back of the claim form, as noted in section 216.000.

223.000 Removable Prosthetic Services (Full and Partial Dentures, Including Repairs) 4-1-05

Full and acrylic partial dentures are allowable for patients under age 21. Full dentures or acrylic partial dentures may be approved for use by individuals under age 21 instead of fixed bridges. A complete series of X-rays and a complete treatment plan, including tooth numbers to be replaced by full or partial dentures, must be submitted with requests for full or acrylic partial dentures. All dentures, either full or acrylic partials, require prior authorization.

Repairs of dentures are allowable with a history and date of original insertion and prior authorization for eligible recipients under age 21. See section 262.100 for applicable procedure codes.

226.000 Orthodontics 4-1-05

Orthodontic treatment is available for eligible recipients under age 21 with prior authorization. Orthodontic treatment is approved on a very selective basis when a handicapping malocclusion is affecting the patient's physical and/or psychological health. The dental provider is responsible for evaluating the attitude of the patient and the parent/guardian toward the treatment and their ability and/or willingness to follow instructions and meet appointments promptly. This evaluation should precede taking orthodontic records. **Please note: ARKids First-B does not cover orthodontic treatment.**

All orthodontic treatment is classified as either minor treatment for tooth guidance or as comprehensive treatment. Minor treatment for tooth guidance will be allowed with prior authorization when necessary to correct functional problems.

All orthodontic treatment, including functional appliances, must be requested on the ADA claim form. The ADA claim form must be accompanied by the Request for Orthodontic Treatment form (form DMS-32-0). **View or print form DMS-32-0**.

The maximum age of eligibility for full-banded 24-month orthodontic treatment is through age 20. Functional-banded orthopedic appliances require the same diagnostic records as full-banded orthodontics. The minimum total score on a Request for Orthodontic Treatment for consideration of comprehensive orthodontic treatment is 26. This value will be rescored by a Medicaid dental consultant based on the casts and radiographs provided with the request.

Diagnostic casts (dental molds), cephalometric film, photos, a complete series of X-rays and any information not evident on diagnostic materials must be submitted for review with the ADA claim form. Dental molds must be submitted along with the treatment plan. The dental molds must not be submitted separately and the provider's and the recipient's full names must be clearly inscribed on the upper and lower casts.

If oral surgery is necessary in addition to orthodontic treatment, the oral surgeon must submit his or her treatment plan with the orthodontic treatment plan.

When orthodontic treatment is approved, a procedure code for appliance insertion will be issued. This procedure code includes payment for the appliance, the diagnostic records, casts (dental molds and X-rays) and the post-treatment retainer. This code and the prior authorization control number will be sent to the provider on the ADA form. The date the treatment is to be completed will also be indicated. No reimbursement for treatment beyond that date will be made. The Authorization for Payment for Services Provided form (form MAP-8) and a copy of the treatment plan must be kept by the provider in the patient's file. **View or print MAP-8 form and instructions.**

When treatment is denied or for any reason is not performed, the provider is allowed to submit a claim for the orthodontic records. This includes orthodontic consultation, cephalometric film, diagnostic casts (dental molds), photos and a complete series or panoramic X-ray if taken by the dentist. This claim must be approved by the Medicaid dental consultant.

All claims for orthodontic treatment are to be submitted on the ADA claim form according to directions detailed in section 262.300 of this manual. Claims must be submitted within 12 months from the date of service.

When a patient is uncooperative for any reason, except for the situation noted in the following paragraph, termination of the treatment will be left to the discretion of the provider. A report should be sent to the Division of Medical Services, Dental Care Unit, with a pro-rated refund to Arkansas Medicaid for the balance of the uncompleted treatment plan. **View or print DMS Dental Care Unit contact information.**

When an orthodontic patient moves within the state after initial treatment has begun, the original provider should reimburse the second provider directly for the pro-rated fees remaining. When the second provider submits his or her treatment plan to continue the orthodontic patient's

treatment, the provider must submit the orthodontic records of treatment performed by the original provider.

229.000 Adult Services 4-1-05

In general, Arkansas Medicaid does not cover dental treatment for adults who are 21 years of age and older. An exception to this general rule is dental treatment that is medically necessary.

Medically necessary dental treatment is defined as dental care that will stabilize a life-threatening medical condition, or dental care that, if not done, could result in death.

All medically necessary dental care must be pre-approved by medical and dental consultants at the Division of Medical Services. All adult dental care services may only be submitted on paper claims.

The review process must include:

A. The identification of a life-threatening medical problem affected by oral health**.** Some examples of such conditions are:

1. HIV/AIDS patients with infections the immune system is unable to fight
2. Transplant patients with infected teeth or gums
3. Cancer radiation treatments to the head/neck/jaw

B. The PCP Referral Form (DMS-2610) must be completed by the primary care physician detailing the medical condition and the effects the oral health problems have on the overall health of the recipient. **View or print form DMS-2610**.

C. Upon completion, the PCP Referral Form (DMS-2610) must be submitted to the Division of Medical Services by the dental professional who will be providing the services. Any supporting information, including X-rays, to further substantiate medically necessary treatment must be submitted.

D. Upon receipt, Medicaid medical and dental consultants will evaluate the information submitted and authorize the dental treatment, if any, that Medicaid will reimburse. After the review process is completed, the panel will return any X-rays along with recommendations to the requesting dental professional.

E. The office of the dental professional will notify the recipient regarding the decision of the Medicaid consultants, and if appropriate, arrange to begin dental care.

The medical/dental consultants will only approve dental treatment for adults who strictly meet the medical necessity criteria.

Under no circumstance will the Dental Program purchase dentures or any other similar prosthetic device for individuals age 21 and over. Oral surgery, such as reconstructive surgery for cosmetic purposes, is not a covered service, nor are implants a covered service.

260.000 BILLING PROCEDURES 4-1-05

261.000 Introduction to Billing 4-1-05

Dental providers must use the American Dental Association (ADA) form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid recipients. Each claim may contain charges for only one recipient.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

262.000 ADA Billing Procedures 4-1-05

262.100 ADA Procedure Codes 4-1-05

The following ADA procedure codes are covered by the Arkansas Medicaid Program. These codes are payable for individuals under the age of 21. The codes are non-payable for individuals age 21 and over unless a life-threatening medical necessity exists.

Beside each code is a reference chart that indicates if X-rays are required, if prior authorization (PA) is required and the age group(s) for which the procedure is covered.

ADA Code	Description	Coverage Under 21	Coverage 21 and Over	Submit X-Ray with Treatment Plan
Child Health Services (EPSDT) Dental Screening (See section 215.000)				
D0120	CHS/EPSDT initial dental Exam	Yes	No	No
D0140	CHS/EPSDT interperiodic dental Exam	Yes W-PA	No	No
Radiographs (See sections 216.000 – 216.300)				
D0210	Intraoral – complete series (including bitewings)	Yes	No	No
D0220	Intraoral – periapical - first film	Yes	No	No
D0230	Intraoral – periapical - each additional film	Yes	No	No
D0240	Intraoral – occusal film	Yes	No	No
D0250	Extraoral - first film	Yes	No	No
D0260	Extraoral - each additional film	Yes	No	No
D0272	Bitewings - two films	Yes	No	No
D0330	Panoramic film	Yes	No	No
D0340	Cephalometric film	Yes W-PA	No	No
Tests and Laboratory				
D0470	Diagnostic casts	Yes W-PA	No	No
D0350	Diagnostic photographs	Yes W-PA	No	No
Preventive				
Dental Prophylaxis (See section 217.100)				
D1120	Prophylaxis – child (ages 0-9)	Yes	No	No

ADA Code	Description	Coverage Under 21	Coverage 21 and Over	Submit X-Ray with Treatment Plan
D1110	Prophylaxis – adult (ages 10-20)	Yes	No	No
Topical Fluoride Treatment (Office Procedure) (See Section 217.100)				
D1201	Topical application of fluoride (including prophylaxis) - child (ages 0-9)	Yes	No	No
D1205	Topical application of fluoride (including prophylaxis) - adult (ages 10-20)	Yes	No	No
Dental Sealants (See section 217.200)				
D1351	Sealant per tooth (1st and 2nd permanent molars only)	Yes	No	No
Space Maintainers (See section 218.000)				
D1510	Space maintainer - fixed – unilateral	Yes W-PA	No	Yes
D1515	Space maintainer - fixed – bilateral	Yes W-PA	No	Yes
D1525	Space maintainer - removable-bilateral	Yes W-PA	No	Yes
Restorations (See sections 219.000 – 219.200)				
Amalgam Restorations (including polishing) (See section 219.100)				
D2140	Amalgam – one surface	Yes	No	No
D2150	Amalgam – two surfaces	Yes	No	No
D2160	Amalgam - three surfaces	Yes	No	No
D2161	Amalgam - four or more surfaces	Yes	No	No
Composite Resin Restorations (See section 219.200)				
D2330	Resin - one surface, anterior, permanent	Yes	No	No
D2331	Resin - two surfaces, anterior, permanent	Yes	No	No
D2332	Resin - three surfaces, anterior, permanent	Yes	No	No
D2335	Resin - four or more surfaces or involving incisal angle, permanent	Yes W-PA	No	Yes
Crowns-Single Restoration Only (See section 220.000)				
D2710	Crown - resin (laboratory)	Yes W-PA	No	Yes
D2752	Crown - porcelain-ceramic substrate	Yes W-PA	No	Yes
D2920	Re-cement crown	Yes	No	Yes
D2930	Prefabricated stainless steel crown - primary	Yes	No	No
D2931	Prefabricated stainless steel crown - permanent	Yes W-PA	No	Yes

ADA Code	Description	Coverage Under 21	Coverage 21 and Over	Submit X-Ray with Treatment Plan
Endodontia (See section 221.000)				
Pulpotomy				
D3220	Therapeutic pulpotomy (excluding final restoration)	Yes	No	No
D3221	Gross pulpal debridement, primary and permanent teeth	Yes W-PA	No	No
Root canal therapy (including treatment plan, clinical procedures and follow-up care)				
D3310	One canal (excluding final restoration)	Yes W-PA	No	Yes
D3320	Two canals (excluding final restoration)	Yes W-PA	No	Yes
D3330	Three canals (excluding final restoration)	Yes W-PA	No	Yes
Periapical Services				
D3410	Apicoectomy (per tooth) - first root	Yes W-PA	No	Yes
Periodontal Procedures (See section 222.000)				
Surgical Services (including usual postoperative services)				
D4341	Periodontal scaling and root planing	Yes W-PA	No	Yes
D4910	Periodontal maintenance procedures (following active therapy)	Yes W-PA	No	Yes
Complete dentures (Removable Prosthetics Services) (See section 223.000)				
D5110	Complete denture – maxillary	Yes W-PA	No	Yes
D5120	Complete denture – mandibular	Yes W-PA	No	Yes
Partial Dentures (Removable Prosthetic Services) (See section 223.000)				
D5211	Upper partial - acrylic base (including any conventional clasps and rests)	Yes W-PA	No	Yes
D5212	Lower partial - acrylic base (including any conventional clasps and rests)	Yes W-PA	No	Yes
Repairs to Partial Denture (See section 223.000)				
D5610	Repair acrylic saddle or base	Yes W-PA	No	No
D5620	Repair cast framework	Yes W-PA	No	No
D5640	Replace broken teeth - per tooth	Yes W-PA	No	No
D5650	Add tooth to existing partial denture	Yes W-PA	No	No
Fixed Prosthodontic Services (See section 224.000)				
D6930	Re-cement bridge	Yes W-PA	No	No
Oral Surgery (See section 225.000)				
Simple Extractions – (includes local anesthesia and routine postoperative care) (See section 225.100)				
D7140	Single tooth	Yes	No	No

ADA Code	Description	Coverage Under 21	Coverage 21 and Over	Submit X-Ray with Treatment Plan
D7111	Each additional tooth	Yes	No	No
Surgical Extractions – (includes local anesthesia and routine postoperative care) (See section 225.200)				
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	Yes W-PA	No	Yes
D7220	Removal of impacted tooth -soft tissue	Yes W-PA	No	Yes
D7230	Removal of impacted tooth -partially bony	Yes W-PA	No	Yes
D7240	Removal of impacted tooth -completely bony	Yes W-PA	No	Yes
D7241	Removal of impacted tooth -completely bony, with unusual surgical complications	Yes W-PA	No	Yes
D7250	Surgical removal of residual tooth roots (cutting procedure)	Yes W-PA	No	Yes
Other Surgical Procedures				
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	Yes W-PA	No	Yes
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)	Yes W-PA	No	Yes
D7285	Biopsy of oral tissue - hard	Yes W-PA	No	Yes
D7286	Biopsy of oral tissue - soft	Yes W-PA	No	Yes
Osteoplasty for Prognathism, Micrognathism or Apertognathism				
D7510	Incision and drainage of abscess, intraoral soft tissue	Yes W-PA	No	No
Other Repair Procedures				
Bill on paper	LeFort I (maxilla-segmented)	Yes By-RPT	No	Yes
Frenulectomy				
D7960	Frenulectomy (Frenectomy or Frenotomy) Separate procedure	Yes W-PA	No	Yes
Orthodontics (See section 226.000)				
Minor Treatment of Control Harmful Habits				
D8210	Removable appliance therapy	Yes W-PA	No	Yes
D8220	Fixed appliance therapy	Yes W-PA	No	Yes
Comprehensive Orthodontic Treatment – Permanent Dentition				
D8070	Class I Malocclusion	Yes W-PA	No	Yes

ADA Code	Description	Coverage Under 21	Coverage 21 and Over	Submit X-Ray with Treatment Plan
D8080	Class II Malocclusion	Yes W-PA	No	Yes
D8090	Class III Malocclusion	Yes W-PA	No	Yes
Other Orthodontic Devices				
D8999	Unspecified orthodontic procedure, by report	Yes W-PA	No	Yes
D9110	Palliative treatment with dental pain	Yes W-PA	No	No
D9220	General Anesthesia - first 30 minutes	Yes W-PA	No	Yes
D9221	General Anesthesia – each 15 minutes	Yes W-PA	No	No
D9230	Analgesia N20	Yes *By RPT for request for more than 1 unit per day	No	No
D9630	Conscious Sedation	Yes W-PA By RPT	No	No
Professional Visits (See section 227.000)				
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	Yes W-PA	No	No
D9440	Office visit - after regularly scheduled hours	Yes W-PA	No	No
Inpatient Hospital Services (See section 228.100)				
D9220	Inpatient hospitalization – for hospital only	Yes W-PA	No	No
Outpatient Hospital Services (See section 228.200)				
0361*	Outpatient hospitalization - for hospital only	Yes W-PA	No	No
0360*	Outpatient hospitalization - for hospital only	Yes W-PA	No	No
0369*	Outpatient hospitalization - for hospital only	Yes W-PA	No	No
0509*	Outpatient hospitalization - for hospital only	Yes W-PA	No	No

* Revenue code

Procedure codes D9220 and D9221 are payable for individuals over age 21 when provided as medically necessary dental treatment. See section 229.000 for a description of medically necessary dental treatment for adults.

262.400 Special Billing Procedures for ADA Claim Form 4-1-05

A. Each procedure must be shown on a separate line, such as:

1. Extractions
2. Upper partials
3. Lower partials
4. Upper denture relines
5. Lower denture relines

B. When a complete intraoral series is made, the dentist must use procedure code D0210 rather than indicating each intraoral film on a separate line.

C. When submitting a claim for an intraoral single film, indicate the middle tooth number. Procedure code D0220 must be used for the first film and procedure code D0230 for each additional single film. Medicaid will only cover the complete series or the submitted group of individual X-rays. X-rays are to be mounted, marked R and L, labeled with the dentist's provider number and the recipient identification number and stapled to the back of the claim form.

D. Post-operative X-rays must accompany all claims with root canals. The claim and X-rays should be sent to the Arkansas Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information**.

E. Prophylaxis and fluoride must be indicated on the same line of the form using code D1201 for patients age 9 and under and D1205 for patients ages 10 through 20. If prophylaxis and fluoride are submitted as separate procedures, they will be combined on the claim before processing them for payment.

F. Indicate the tooth number when submitting claims for code D0220 and D0230, intraoral single film. When a complete series is made, providers must use code D0210 rather than indicating each tooth on a separate line.

G. Upper and lower full dentures must be billed on a separate line, using the appropriate code for upper or lower dentures.

H. The ADA claim form on which the treatment plan was submitted to obtain prior authorization may be used to submit the claim for payment. If this is done, only the Request for Payment portion of the form is to be completed. If not, a new form may be used with the prior authorization control number indicated in Field 9 of the claim form. If a new form is used, the patient and provider data and the request for payment sections must be completed.

I. Combine all four quadrants times 2, 3 or 4 when using procedure codes 04210 (gingivectomy or gingivoplasty-per quadrant) and D4220 (gingival curettage, by report).

J. Use procedure code D1110 for prophylaxis-adolescent, ages 10 through 20, and procedure code D1120 for prophylaxis-child, ages 0 through 9.

263.000 CMS-1500 Billing Procedures 4-1-05

Oral surgeons billing CPT procedure codes must use the CMS-1500 form.

263.100 CPT Procedure Codes 4-1-05

Procedure Codes

10060	10061	10120	10121	10140	10160	10180	11000
11001	11040	11041	11042	11043	11044	11050	11051
11052	11101	11200	11201	11305	11306	11307	11308
11310	11311	11312	11313	11420	11440	11620	11621
11622	11623	11624	11626	11640	11641	11642	11643
11644	11646	12001	12002	12004	12005	12006	12007
12011	12013	12014	12015	12016	12017	12018	12020
12021	12031	12032	12034	12035	12036	12037	12041
12042	12044	12045	12046	12047	12051	12052	12053
12054	12055	12056	12057	13120	13121	13131	13132
13150	13151	13152	13160	13300	14020	14021	14040
14041	14060	14061	14300	15000	15100	15101	15120
15121	15220	15221	15240	15241	15260	15261	15350
15400	15570	15572	15574	15576	15580	15600	15610
15620	15630	15732	15740	15750	15755	15760	15770
15840	15841	15842	15845	15850	15851	15852	15860
16000	16010	16015	16020	16025	16030	16035	16040
16041	16042	17000	17001	17002	17010	17107	17108
17110	17200	17201	17250	17270	17271	17272	17273
17274	17276	17280	17281	17282	17283	17284	17286
17304	17305	17306	17307	17310	17340	17999	20000
20005	20525	20605	20615	20670	20680	20690	20692
20693	20694	20900	20902	20910	20912	20920	20922
20924	20926	20960	20962	20969	20970	20971	20999
21010	21015	21025	21026	21029	21030	21031	21032
21034	21040	21041	21044	21045	21050	21060	21070
21100	21110	21116	21206	21210	21215	21230	21235
21240	21242	21243	21260	21261	21263	21267	21268
21270	21275	21280	21282	21295	21296	21299	21300
21315	21320	21325	21330	21335	21336	21337	21338
21339	21340	21343	21344	21345	21346	21347	21348
21355	21356	21360	21365	21366	21385	21386	21387
21390	21395	21400	21401	21406	21407	21408	21421
21422	21423	21431	21432	21433	21435	21436	21440
21445	21450	21451	21452	21453	21454	21461	21462
21465	21470	21480	21485	21490	21493	21494	21495
21499	21501	21550	21555	21557	29800	29804	29909

30000	30020	30100	30117	30118	30120	30124	30125
30130	30140	30150	30160	30200	30210	30220	30300
30310	30320	30520	30540	30545	30560	30580	30600
30620	30630	30801	30802	30901	30903	30905	30906
30915	30920	30930	30999	31000	31002	31020	31030
30132	30140	31050	31051	31070	31075	31080	31081
31084	31085	31086	31087	31090	31225	31230	31231
31233	31235	31237	31238	31239	31240	31276	31287
31288	31290	31291	31292	31293	31294	31299	31500
31502	31513	31515	31530	31531	31535	31536	31600
31601	31603	31605	31820	31825	31830	36000	36400
36405	36406	36410	36600	36620	36625	38300	38505
38525	38542	38700	38720	38724	38740	38745	40490
40500	40510	40520	40525	40527	40530	40650	40652
40654	40700	40701	40702	40720	40761	40799	40800
40801	40806	40808	40810	40812	40814	40816	40818
40820	40830	40831	40840	40842	40843	40844	40845
40899	41000	41005	41006	41007	41008	41009	41010
41015	41016	41017	41018	41108	41110	41112	41113
41114	41116	41120	41130	41135	41140	41145	41150
41153	41155	41250	41251	41252	41500	41510	41520
41599	41800	41805	41806	41820	41821	41822	41823
41825	41826	41827	41828	41830	41850	41870	41872
41874	41899	42000	42100	42104	42106	42107	42120
42140	42145	42160	42180	42182	42200	42205	42210
42215	42220	42225	42226	42227	42235	42260	42280
42281	42299	42300	42305	42310	42320	42325	42326
42330	42335	42340	42400	42405	42408	42409	42410
42415	42420	42425	42426	42440	42450	42500	42505
42507	42508	42509	42510	42550	42600	42650	42660
42665	42699	42720	42725	42800	42802	42804	42806
42808	42810	42815	42880	42900	42950	42953	42960
42961	42962	42970	42971	42972	42999	43204	43205
43219	43227	43228	64400	64402	64405	64550	64716
64722	64727	64732	64734	64736	64738	64740	64742
64744	64788	64790	64792	64795	64830	64864	64872
64874	64885	64886	64901	64902	64905	64907	64999

67599	67715	67810	67820	67825	67830	67835	67875
67880	67882	67902	67903	67904	67906	67908	67909
67911	67930	67935	67950	67961	67966	67971	67973
67974	67975	67999	68400	68420	68440	68530	68720
68745	68750	68760	68761	68770	68800	68825	68840
68850	68899	69100	69110	69200	69205	69210	69399
70030	70100	70110	70140	70150	70160	70170	70210
70220	70250	70260	70300	70310	70320	70328	70330
70332	70336	70350	70355	70360	70380	70390	76000
76100	76140	76499	90780	90799	92511	95831	95851
95868	95937	95999	97010	97014	97124	97703	99201
99202	99203	99204	99205	99211	99212	99213	99214
99215	99217	99218	99219	99220	99221	99222	99223
99231	99232	99233	99238	99241	99242	99243	99244
99245	99251	99252	99253	99254	99255	99271	99272
99273	99274	99275	99281	99282	99283	99284	99285
99288	99301	99302	99303	99311	99312	99313	99341
99342	99343	99351	99352	99353	99354	99355	99356
99357							

A. The procedures listed above must be billed with the appropriate type of service code (1, Medical), (2, Surgical) or (C, P or T - Lab, X-Ray, or Machine Test).

B. Enter the type of service code in Field 24C of the CMS-1500 claim form.

C. If these procedures are the result of a Child Health Services (EPSDT) screen/referral, enter “E” in Field 24H.

D. These procedures are restricted to the following places of service: inpatient hospital, outpatient hospital, doctor’s office, patient’s home, nursing home and skilled nursing facility.

E. Radiology procedures are payable only in the dentist’s office. The place of service (POS) codes may be found in section 262.200 of this manual. **These services require a PCP referral.**

The claim form CMS-1500 must be used by dentists billing the Medicaid Program for these medical procedures. Each recipient’s services must be billed on a separate form. See section 263.300 for complete billing instructions.

When billing for extractions (procedure code 41899), a listing of teeth extracted by date, tooth number and ADA code number must be attached.

Recipients in the Child Health Services (EPSDT) Program are not benefit limited.

The provider should carefully read and adhere to the following instructions so that claims may be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible. Handwritten claims must be completed neatly and accurately.

263.300 Billing Instructions - CMS-1500 - Paper Claims Only 4-1-05

The CMS-1500 claim form must be completed when billing for procedure codes listed in sections 263.100 through 263.110. The following numbered items correspond to numbered fields on the claim form. **View a CMS-1500 sample form**.

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

COMPLETION OF FORM

Field Name and Number		Instructions for Completion
1.	Type of Coverage	This field is not required for Medicaid.
1a.	Insured's I.D. Number	Enter the patient's 10-digit Medicaid identification number.
2.	Patient's Name	Enter the patient's last name and first name.
3.	Patient's Birth Date	Enter the patient's date of birth in MM/DD/YY format as it appears on the Medicaid identification card.
	Sex	Check "M" for male or "F" for female.
4.	Insured's Name	Required if there is insurance affecting this claim. Enter the insured's last name, first name and middle initial.
5.	Patient's Address	Optional entry. Enter the patient's full mailing address, including street number and name (post office box or RFD), city name, state name and ZIP code.
6.	Patient Relationship to Insured	Check the appropriate box indicating the patient's relationship to the insured if there is insurance affecting this claim.
7.	Insured's Address	Required if insured's address is different from the patient's address.
8.	Patient Status	This field is not required for Medicaid.
9.	Other Insured's Name	If patient has other insurance coverage as indicated in Field 11D, enter the other insured's last name, first name and middle initial.
	a. Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
	b. Other Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.
	c. Employer's Name or School Name	Enter the employer's name or school name.
	d. Insurance Plan Name or Program Name	Enter the name of the insurance company.
10.	Is Patient's Condition Related to:	

	a. Employment	Check “YES” if the patient’s condition was employment related (current or previous). If the condition was not employment related, check “NO.”
	b. Auto Accident	Check the appropriate box if the patient’s condition was auto accident related. If “YES,” enter the place (two-letter state postal abbreviation) where the accident took place. Check “NO” if not auto accident related.
	c. Other Accident	Check “YES” if the patient’s condition was other accident related. Check “NO” if not other accident related.
10d.	Reserved for Local Use	This field is not required for Medicaid.
11.	Insured’s Policy Group or FECA Number	Enter the insured’s policy group or FECA number.
	a. Insured’s Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.
	b. Employer’s Name or School Name	Enter the insured’s employer’s name or school name.
	c. Insurance Plan Name or Program Name	Enter the name of the insurance company.
	d. Is There Another Health Benefit Plan?	Check the appropriate box indicating whether there is another health benefit plan.
12.	Patient’s or Authorized Person’s Signature	This field is not required for Medicaid.
13.	Insured’s or Authorized Person’s Signature	This field is not required for Medicaid.
14.	Date of Current: Illness Injury Pregnancy	Required only if medical care being billed is related to an accident. Enter the date of the accident.
15.	If Patient Has Had Same or Similar Illness, Give First Date	This field is not required for Medicaid.
16.	Dates Patient Unable to Work in Current Occupation	This field is not required for Medicaid.
17.	Name of Referring Physician or Other Source	Primary care physician (PCP) referral is not required for dental services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a.	I.D. Number of Referring Physician	Enter the 9-digit Medicaid provider number of the referring physician.
18.	Hospitalization Dates Related to Current Services	For services related to hospitalization, enter hospital admission and discharge dates in MM/DD/YY format.
19.	Reserved for Local Use	Not applicable to dental.
20.	Outside Lab?	This field is not required for Medicaid.

21. Diagnosis or Nature of Illness or Injury	Enter the diagnosis code from the ICD-9-CM. Up to four diagnoses may be listed. Arkansas Medicaid requires providers to comply with CMS diagnosis coding requirements found in the ICD-9-CM edition current for the claim receipt dates.
22. Medicaid Resubmission Code	Reserved for future use.
Original Ref No.	Reserved for future use.
23. Prior Authorization Number	Enter the prior authorization number, if applicable.
24. A. Dates of Service	Enter the "from" and "to" dates of service, in MM/DD/YY format, for each billed service. 1. On a single claim detail (one charge on one line), bill only for services within a single calendar month. 2. Providers may bill, on the same claim detail, for two (2) or more *sequential* dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the span.
B. Place of Service	Enter the appropriate place of service code. See section 263.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See section 263.200 for codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from sections 263.100 through 263.110.
Modifier	Use applicable modifier.
E. Diagnosis Code	Enter a diagnosis code that corresponds to the diagnosis in Field 21. If preferred, simply enter the corresponding line number ("1," "2," "3," "4") from Field 21 on the appropriate line in Field 24E instead of reentering the actual corresponding diagnosis code. Enter only <u>one</u> diagnosis code or one diagnosis code line number on each line of the claim. If two or more diagnosis codes apply to a service, use the code most appropriate to that service. The diagnosis codes are found in the ICD-9-CM.
F. $ Charges	Enter the charge for the service. This charge should be the provider's usual charge to private clients. If more than one unit of service is being billed, enter the charge for the total number of units billed.
G. Days or Units	Enter the units (in whole numbers) of service rendered within the time frame indicated in Field 24A.
H. EPSDT/Family Plan	Enter "E" if services rendered were a result of a Child Health Services (EPSDT) screening/referral.
I. EMG	Emergency - This field is not required for Medicaid.
J. COB	Coordination of Benefit - This field is not required for Medicaid.

	K. Reserved for Local Use	When billing for a clinic or group practice, enter the 9-digit Medicaid provider number of the performing provider in this field and enter the group provider number in Field 33 after "GRP#." When billing for an individual practitioner whose income is reported by 1099 under a Social Security number, DO NOT enter the provider number here. Enter the number in Field 33 after "GRP#."
25.	Federal Tax I.D. Number	This field is not required for Medicaid. This information is carried in the provider's Medicaid file. If it changes, contact Provider Enrollment.
26.	Patient's Account No.	This is an optional entry that may be used for accounting purposes. Enter the patient's account number, if applicable. Up to 16 numeric or alphabetic characters will be accepted.
27.	Accept Assignment	This field is not required for Medicaid. Assignment is automatically accepted by the provider when billing Medicaid.
28.	Total Charge	Enter the total of Field 24F. This field should contain a sum of charges for all services indicated on the claim form. (See NOTE below Field 30.)
29.	Amount Paid	Enter the total amount of funds received from other sources. The source of payment should be indicated in Field 11 and/or Field 9. Do not enter any amount previously paid by Medicaid. Do not enter any payment by the recipient unless the recipient has an insurer that requires co-pay. In such a case, enter the sum of the insurer's payment and the recipient's co-pay amount, without regard to whether the recipient has remitted the co-pay. (See NOTE below Field 30.)
30.	Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge. **NOTE: For Fields 28, 29 and 30, up to 28 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.**
31.	Signature of Physician or Supplier, Including Degrees or Credentials	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32.	Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	If other than home or office, enter the name and address, specifying the street, city, state and ZIP code of the location where services were performed.

33. Physician's/Supplier's Billing Name, Address, ZIP Code & Phone #	Enter the billing provider's name and complete address. Telephone number is requested but not required.
PIN #	This field is not required for Medicaid.
GRP #	Clinic or Group Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#" and the individual practitioner's number in Field 24K. Individual Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#."

263.400 Special Billing Procedure for the CMS-1500 Claim Form 4-1-05

CPT-4 procedure codes must be billed on the CMS-1500 claim form by dentists enrolled in the Medicaid Program when the procedure is provided to an eligible Medicaid recipient and is medically necessary. **View a CMS-1500 sample form.** These procedure codes and their descriptions are located in the *American Medical Association Current Procedural Terminology (CPT)*. Refer to Section III for information on how to purchase a copy of this publication.

NOTE: The Arkansas Medicaid Program will make procedure code 99238 (Hospital Discharge Day Management) payable for type of service code "1" (Medical). Procedure code 99238 may not be billed by providers in conjunction with an initial or subsequent hospital care code (procedure codes 99221 through 99233). Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

NOTE: Covered CPT-4 procedure codes listed in this section are covered by Medicaid for eligible recipients of all ages. The Arkansas Medicaid ADA Procedure Codes are covered only for eligible recipients under the age of 21 years participating in the Child Health Services (EPSDT) Program.

263.410 Multiple Quadrants Billing Instructions 4-1-05

When billing for multiple applications of any of the following procedures on the same date of service in varying quadrants of a recipient's mouth, indicate the number of quadrants (1, 2, 3, 4) in Field 24G:

D1110	D1120	41872	41874

263.420 Anesthesia Services 4-1-05

Anesthesia services are billed using the CMS-1500 claim format.

A. The Arkansas Medicaid Program covers the anesthesia procedure codes (code range 00100 through 01999) listed in the *Current Procedural Terminology (CPT-4*) code book.

B. Providers must use a type of service (TOS) code "7" with the anesthesia procedure codes and must bill anesthesia time.

C. Providers must use anesthesia modifiers P1 through P5 as listed in the CPT manual.

D. Providers may bill electronically unless paper attachments are required.

E. When providers bill on paper, a TOS code is required along with any applicable modifier(s).

The procedure code and the time involved must be entered in Field 24D. The number of units (each 15 minutes, or portion thereof, of anesthesia equals 1 time unit) must be entered in Field 24G. A "7" must be entered in Field 24C. (A cutaway section of a completed claim is located in section 263.422.)

The procedure code listed under the "Qualifying Circumstances" in the Anesthesia Guidelines in the CPT requires a TOS code "1." When surgical field avoidance is a qualifying factor of the anesthesia service, the provider must bill, in addition to the basic anesthesia procedure code, modifier 22, TOS code "1" and must bill "1" unit of service.

Procedure code 00170 may be billed using TOS code "7" for any inpatient or outpatient dental surgery using place of service code "B," "1," "2" or "3," as appropriate. This code does not require prior approval for anesthesia claims.

263.422 Example of Proper Completion of Claim 4-1-05

The following is a cutaway section of the CMS-1500 claim form demonstrating the proper method of entering the following information:

Line No. 1 - Anesthesia for Procedure

Line No. 2 - Qualifying Circumstance

DATE(S) OF SERVICE From MM DD YY	To MM DD YY	Place of Service	Type of Service	PROCEDURES, SERVICES OR SUPPLIES (Explains Unusual Circumstances) CPT HCPCS	Modifier	DIAGNOSIS CODE	S CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
07 15 95		1	7	00170	P3	525.9	xxx xx	4				105967001
				60 minutes	= 4 units							
07 15 95		1	1	99100		525.9	xxx xx	1				105967001